

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/27/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>The visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN 00131315 Unsubstantiated; lack of sufficient evidence.</p> <p>Survey Date: 11-27-13</p> <p>Facility Number: 005068</p> <p>Surveyor: Brian Montgomery, RN Public Health Nurse Surveyor</p> <p>Community Hospital East is in compliance with 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing service and 410 IAC 15-1.5-10, Utilization review and discharge planning services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 12/04/13</p>	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE